Site-of-Service (SOS) Payment Differential

How Are Fees Established for Professional Services Performed in Facility and Nonfacility Settings?

Based on the Resource Based Relative Value Scale (RBRVS) methodology, the Department's fee schedule amounts are established using three relative value unit (RVU) components: work, practice expense, and malpractice expense. The Department uses two levels of practice expense components to determine the fee schedule amounts for reimbursing professional services. This may result in two RBRVS maximum allowable fees for a procedure code. These are:

- **Facility setting maximum allowable fees (FS Fee) -** Paid when the provider performs the services in a facility setting (e.g., a hospital or ambulatory surgery center) and the cost of the resources are the responsibility of the facility; or

- **Non-facility setting maximum allowable fees (NFS Fee) -** Paid when the provider performs the service in a non-facility setting (e.g., office or clinic) and typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed.

Some services, by nature of their description, are performed only in certain settings and have only one maximum allowable fee per code. Examples of these services include:

- Evaluation and management (E&M) codes which specify the site-of-service (SOS) within the description of the procedure codes (e.g., initial hospital care); and

- Major surgical procedures that are generally performed only in hospital settings.

How Does the SOS Payment Policy Affect Provider Payments?

Providers billing professional services are paid at one of two maximum allowable fees, depending on where the service is performed.

Does the Department Pay Providers Differently for Services Performed in Facility and Nonfacility Settings?

Yes. When a provider performs a professional service in a facility setting, the Department makes two payments - one to the performing provider and another to the facility. The payment to the provider (FS Fee) includes the provider's professional services only. A separate payment is made directly to the facility where the service took place, which includes payment for necessary resources. The FS Fee excludes the allowance for resources that are included in the payment to the facility. Paying the lower FS Fee to the performing provider when the facility is also paid eliminates duplicate payment for resources.

When a provider performs a professional service in a non-facility setting, the Department makes only one payment to the performing provider. The payment to the provider (NFS Fee) includes the provider's professional services and payment for necessary resources.

When Are Professional Services Paid at the Facility Setting Maximum Allowable Fee?

Providers are paid at the FS Fee when the Department also makes a payment to a facility. In most cases, the Department follows Medicare's determination for using the FS Fee. Professional services billed with the following place of service codes are paid at the FS Fee:

FACILITY SETTING

Place of Service Code	Place of Service Description
06	Indian Health Service – provider based
08	Tribal 638 – provider based
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility

FACILITY SETTING (cont.)

Place of Service Code	Place of Service Description
34	Hospice
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility

Note: All claims submitted to the Department must include the appropriate Medicare **two-digit place of service code.** The Department will deny claims with single-digit place of service codes.

Due to Medicare's consolidated billing requirements, the Department does not make a separate payment to providers who perform certain services in hospitals and skilled nursing facilities. The facilities are paid at the NFS Fee. Some therapies, such as physical therapy services (CPT codes 97001-97799), are always paid at the NFS Fee.

When Are Professional Services Paid at the Nonfacility Setting Maximum Allowable Fee?

The NFS Fee is paid when the Department does not make a separate payment to a facility, such as when services are performed in a provider's office or a client's home. In most cases, the Department follows Medicare's determination for using the NFS Fee.

Professional services billed with the following place of service codes are paid at the NFS Fee:

NONFACILITY SETTING

Place of Service Code	Place of Service Description
04	Homeless Shelter
05	Indian Health – Free Standing
07	Tribal 638 – Free Standing
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
32	Nursing Facility

NONFACILITY SETTING (cont.)

Place of Service Code	Place of Service Description
33	Custodial Care Facility
49	Independent Clinic
50	Federally Qualified Health Center
54	Intermediate Care Facility
55	Residential Substance Abuse Treatment Facility
57	Non-Resident Substance Abuse Treatment Facility
60	Mass Immunization Center
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

Note: All claims submitted to the Department must include the appropriate Medicare **two-digit place of service code.** The Department will deny claims with single-digit place of service codes.

Which Professional Services Have a SOS Payment Differential?

Most of the services with an SOS payment differential are from the surgery, medicine, and E&M ranges of CPT codes. However, some HCPCS, CPT radiology, pathology, and laboratory codes also have an SOS payment differential.

Fee Schedule Information

- Maximum allowable fees for all codes, including CPT codes and selected HCPCS codes, are **listed in the fee schedule**.
- In the fee schedule, the Department identifies procedure codes that may require prior authorization. However, this list may not be all-inclusive. Prior authorization, limitations, or requirements detailed in Department/MPA billing instructions and Washington Administrative Code (WAC) remain applicable.
- Section L contains rate setting methodology and unit rounding instructions for injectable drug codes.
- Many Department/MPA fee schedules are available for download in Excel format online at: http://hrsa.dshs.wa.gov/RBRVS/Index.html.